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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

BLUE CROSS HOSPITAL SERVICE, INC. OF MISSOURI;
MISSOURI MEDICAL SERVICE; and
BLUE CROSS AND BLUE SHIELD OF KANSAS CITY,
Appellants,

vs.

J. H. FRAPPIER, Director of the Department of Consumer Affairs, Regulation and Licensing, State of Missouri; C. DONALD AINSWORTH, Director of the Division of Insurance, State of Missouri; THE MISSOURI PSYCHOLOGICAL ASSOCIATION; MISSOURI PHARMACEUTICAL ASSOCIATION, INC.; and M. EARL CASH,
Appellees,

Appeal from The Supreme Court of the State of Missouri

JURISDICTIONAL STATEMENT

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QUESTIONS PRESENTED

I

Does § 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a), preempt state laws that require Blue Cross and Blue Shield companies to pay for services of particular kinds of health care providers (e.g. chiropractors) in treating beneficiaries of employee benefit plans, although the employee benefit plan contracts made by employers with such companies do not authorize payment for the services of the specified providers?

II

Does § 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a), preempt a state law that requires Blue Cross and Blue Shield companies to make payments directly to pharmacists for drugs provided to beneficiaries of an employee benefit plan pursuant to assignment by the beneficiaries of their right to reimbursement, when such assignments are prohibited by the plan contract?*

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* In accordance with Rule 28.1 of this Court, appellants state that they are non-stock corporations and have no subsidiaries except wholly-owned subsidiaries and no affiliates except non-stock affiliates.

TABLE OF CONTENTS

	Page
Questions Presented	i
Table of Authorities	v
Opinion Below	1
Jurisdiction	1
Statutory Provisions Involved	2
Statement of the Case	2
The Questions Are Substantial	6
A. The Questions Affect Statutes and Contracts In 48 States and Require An Accommodation Of Two Important Federal Policies	6
B. The Challenged Statutes are Preempted by ERISA Because They "Relate To" Employee Benefit Plans	9
(1) The statutes relate to employee plans	9
(2) The statutes should be held preempted by ERISA consistent with prior decisions of this Court	11
C. The Mandated-Provider Statutes Are Not Excepted From ERISA Preemption As "Regulation Of Insurance" Because The Activities Regulated By Those Sections Do Not Satisfy The Court's Criteria For "Insurance"	13
(1) Designating providers whose services are to be paid for does not transfer or spread the insurance risk	16

(2) The arrangements for provider services are not an integral part of the insurance relation 18

(3) The statutes involve persons outside the insurance industry 20

Conclusion 20

App. A Opinion and Judgment of the Supreme Court of Missouri en banc, dated December 18, 1984 A-1

App. B Declaratory Judgment and Permanent Injunction, dated February 27, 1984, entered by the Circuit Court of Cole County, Missouri .. A-16

App. C Order of the Supreme Court, State of Missouri, dated January 15, 1985, overruling plaintiffs' Motion for rehearing A-20

App. D Notice of Appeal to the Supreme Court of the United States filed in the Supreme Court of Missouri on April 1, 1985 ..... A-22

App. E Section 354.010(3)(4) of House Bill 127 as passed A-24

App. F Section 354.027 of House Bill 127 as passed .. A-25

App. G Section 354.090.2 of House Bill 127 as passed A-26

App. H Section 375.936(11)(b) of House Bill 127 as passed A-27

App. I ERISA preemption clause - 29 U.S.C. 1144(a) A-28

ERISA insurance exception to preemption -29 U.S.C. §1144(b)(2)(A) A-28

ERISA definition of "employee welfare benefit plan" - 29 U.S.C. §1002(1)..... A-28

ERISA definition of "employee benefit plan" - 29 U.S.C. §1002(3) A-29

App. K Section 2(b) of the McCarran-Ferguson Act -15 U.S.C. §1012(b) A-30

App. L State laws requiring payment for services rendered by various types of health care providers A-31

TABLE OF AUTHORITIES

Cases:

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) 8, 11

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), *reh. den*, 441 U.S. 917 (1979) . *passim*

Metropolitan Life Insurance Co. v. Massachusetts and The Travelers Insurance Co. v. Massachusetts, No. 84-325 and 84-356 6

SEC v. National Securities, Inc., 393 U.S. 453 (1969) ... 14, 19

Shaw v. Delta Air Lines, Inc., ____ U.S. ____, 103 S.Ct. 2890 (1983) 8, 11

Union Labor Life Insurance Co. v. Pireno, ____ U.S. ____, 102 S.Ct. 3002 (1982) ..... *passim*

Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), cert. den, 450 U.S. 916 (1981) 18

Constitution and Statutes:

United States Constitution, Article VI, Supremacy Clause 4

28 U.S.C. § 1257(2) 2

Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ..... *passim*

McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* ..... *passim*

Missouri Laws 1983, H.B. 127
354.010(4) ..... *passim*
§ 354.027 ..... *passim*
§ 354.090-2 ..... *passim*
375.936(11)(b) ..... *passim*

Missouri Laws on Licensed Health Providers: R.S.Mo. § 190.100(11); § 190.105; § 330.020; § 331.030; § 332.081; § 332.101; § 334.010; § 334.510; § 335.016(5)(9); § 336.020; § 337.015; § 338.010; § 345.020; § 346.015 ..... 10, 11

Miscellaneous:

Blue Cross and Blue Shield Association, Chicago Illinois 8

1 G. Couch, *Cyclopedia of Insurance Law*, § 1.3 (2d Ed. 1959) 15

1 G. Couch, *Cyclopedia of Insurance Law*, § 2.7 at 286-287 (Rev. ed. 1984) 17

R. Keeton, *Insurance Law*, # 1.2a (1971) 15

1 G. Richards, *The Law of Insurance*, § 2 (W. Freedman, 5th ed., 1952) 15

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JURISDICTIONAL STATEMENT

OPINION BELOW

The December 18, 1984 opinion of the Supreme Court of Missouri is reported in 681 S.W. 2d 925 (Mo. banc 1984), (App. A).

JURISDICTION

This is an appeal from a decision of the Supreme Court of Missouri upholding the validity of state statutes; the appellants had brought an action to enjoin the enforcement of the statutes and to declare them unconstitutional on the grounds, *inter alia,* that they related to employee benefit plans and were therefore preempted under Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144). The judgment of

the Supreme Court of Missouri was entered on December 18, 1984. A timely motion for rehearing was denied by that court on January 15, 1985. Notice of appeal to this Court was filed in the Supreme Court of Missouri on April 1, 1985. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(2).

STATUTORY PROVISIONS INVOLVED

Sections 354.010(4), 354.027, 354.090-2 and 375.936(11)(b) of the Missouri Revised Statutes (1984) and the relevant provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1002(1), 1002(3), 1144(a) and 1144(b)(2)(A), are reproduced in App. E through I.

STATEMENT OF THE CASE

In 1983 the Missouri legislature enacted the three statutes at issue in this case as part of House Bill 127; that bill contained detailed regulations of health services corporations and health maintenance organizations. These statutes, as applied to employee benefit plan contracts, require Blue Cross-Blue Shield companies[1] to pay for services of particular categories of health practitioners furnished to plan beneficiaries and to pay some practitioners directly therefor, even though the plan contracts do not authorize such payments.

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[1] The appellants, Blue Cross and Blue Shield Plans, are classified and licensed under Missouri laws as not for profit health services corporations; Section 354.010(4) of the Missouri law defines a health services corporation as follows:

> " 'Health services corporation', any not for profit corporation heretofore or hereafter organized or operating for the purposes of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care and other health care and services, or reimbursement therefor, may be furnished to a member or beneficiary;"

As health services corporations, appellants are subject to the three mandated-provider sections in issue.

The three sections in the Missouri law operate in different ways. Section 354.027, which is the broadest, reads as follows:

> "354.027. A health services corporation which provides its members or beneficiaries with coverage for certain services, or reimbursement therefore, shall provide such coverage or reimbursement in all situations in which the covered service is performed by a person duly licensed to perform such service. No health service corporation may discriminate in its coverage or reimbursement amounts for covered services among persons duly licensed to provide such covered services. The provisions of this section shall not apply to any federally qualified health maintenance organization. This section shall apply to all contracts issued or renewed on or after January 1, 1984." (Mo. L. 1983, H.B. 127; 354.027 RSMo 1984)

This law requires a health services corporation to pay for the services of any person licensed by the state if he performs a type of service which the corporation has agreed to pay for when furnished by a physician or other class of practitioner designated in the contract covering the beneficiary.

Section 375.936(11)(b) (which also applies to insurance companies) makes it an unfair practice in "the business of insurance" not to allow the insured to select a practitioner for the covered service from specific kinds of practitioners named in the statute (e.g., chiropractors, psychologists, pharmacists) (App. H).

Section 354.090-2 provides that a health services corporation must recognize an assignment by a member to a non-participating pharmacist of the member's right to reimbursement under his membership contract. The health services corporation must make payment to the pharmacist even though such assignment is prohibited in the membership contract. (App. G).

Each of the appellants has made numerous contracts for employee benefit plans obligating the appellants to furnish the particular health care services which the employees are entitled to receive under such plans.[2]

The employee benefit plans and the contracts issued by appellants for the benefits generally do not authorize payment for the services of many of the providers mandated by Sections 354.027, and 375.936(11)(b), such as psychologists, optometrists, chiropractors and podiatrists. The effect of these sections is to compel the appellants to pay for services of various providers rendered to the beneficiaries of employee benefit plans, contrary to the agreements of the parties to the employee benefit plans. Section 354.090-2 similarly requires the appellants to honor assignments to non-participating pharmacists even though their contracts prohibit such assignments. These provisions substantially increase the benefit and administration costs of the plans.

On September 27, 1983, appellants commenced this action against the state officials (i) for a declaration that House Bill 127 is invalid for various reasons, including that it is preempted by ERISA, 29 U.S.C. 1144(a), under the Supremacy Clause of the United States Constitution, Article VI, and (ii) for an injunction prohibiting enforcement of the new law. The Missouri Psychological Association, the Missouri Pharmaceutical Association and M. Earl Cash, a licensed chiropractor, were allowed to intervene as defendants and to participate as parties.

After an evidentiary hearing on October 31, 1983, the trial court granted a temporary injunction restraining enforcement

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[2] Appellants also have contracts with health care institutions and practitioners, called "participating providers", under which the providers agree to furnish to the beneficiary the health services covered by the benefit plans in exchange for appellants' agreement to pay the participating providers for such services.

of the law. The hearing on the temporary injunction was treated as the trial on the merits and, on February 27, 1984, the trial court entered a judgment declaring House Bill 127, except for Section 375.936(11)(b), invalid because in violation of provisions in the Missouri Constitution relating to the title of bills and changes of purpose during legislative procees. The trial court did not rule on the ERISA preemption issue.

On cross-appeals, the Missouri Supreme Court found the entire House Bill 127 valid. In particular, the court held that no part of House Bill 127 is preempted by ERISA because (1) the law regulates the appellants rather than their employee benefit plan contracts, and (2) the appellants are engaged in the business of insurance. The court held: "We believe that plaintiffs are within the insurance exemption of ERISA for purposes of state regulation" (App. A). Aside from the insurance exception, the Missouri court rejected preemption on the ground that "The statute in question does not relate to employee benefit plans." The court stated: "Indirect regulation of employee benefit plans is permissible provided the regulation does not interfere with the purpose of ERISA." (App. A).

Appellants filed this appeal after their motion for rehearing was denied by the Missouri Supreme Court.

THE QUESTIONS ARE SUBSTANTIAL

A. The Questions Affect Statutes And Contracts In 48 States And Require An Accommodation Of Two Important Federal Policies

The questions presented by this case are similar to questions presented in two cases now pending in this Court: *Metropolitan Life Insurance Co. v. Massachusetts* and *Travelers Insurance Co. v. Massachusetts* (Nos. 84-325 and 84-356). Those two cases were argued in February, 1985, and are presently under submission in this Court.

The Massachusetts statute involved in the two pending cases is a "mandated-benefit" law; such laws require the insurer to include coverage for specified medical conditions, such as mental illness. The statutes involved in this case are "mandated-provider" laws; such laws do not add to the medical conditions covered by the contract but they require the insurer[3] to pay for services of particular types of health practitioners (e.g., chiropractors) if the beneficiary's medical condition is covered by the employee benefit plan. The services of the mandated providers must be paid for even if the terms of the plan authorize payment only to some other class of health practitioner (e.g., physicians).

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[3] The term "insurer" and "insurance" are used here for convenience to apply to Blue Cross and Blue Shield arrangements as well as to commercial insurance company contracts even though the service benefit contracts of appellants differ from the indemnity policies of insurance companies, and Blue Cross and Blue Shield organizations have been viewed legislatively and judicially as distinct from insurance companies. See discussion in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 225-230. It is not necessary to demonstrate the differences in this case because the exception for regulation of insurance depends on whether the activity regulated by the state law is "insurance", not on the status of the entity conducting the activity. See discussion under point C, *infra*.

If this Court rules in the pending Massachusetts cases that the mandated-benefit statute is invalid under ERISA, then, *a fortiori,* it should rule that the mandated-provider statutes in this case are similarly preempted. While neither type of statute "regulates insurance" (and therefore neither should be preserved by the insurance exception to ERISA's preemption provision), the mandated-provider statutes in this case are even further removed from the regulation of insurance than the mandated-benefit statute in the two Massachusetts cases.

The resolution of the question presented by this case will require an analysis of two major federal policies. ERISA evidences a sweeping federal policy for uniform and exclusively federal regulation of employee benefit plans. Section 514 of ERISA expressly preempts all state laws that relate to employee benefit plans (subject only to the exceptions noted in the statute).

The McCarran-Ferguson Act (15 U.S.C. 1012(b)) (App. K) reflects a long-standing federal policy of leaving the regulation of the insurance business to the states. Section 514(b) of ERISA saves from the broad preemption of Section 514(a) "any law of any State which regulates insurance...."

Do the mandated provider statutes involved in this case "regulate insurance"? Are they protected by the federal policy of leaving the regulation of insurance to the states? Or, are they in effect an impermissible effort to impose on the uniform and national regulation of employee benefit plans a crazy-quilt patchwork of local requirements—requirements that would destroy any uniformity of benefits or procedures? Because so many states have adopted so many mandated-provider statutes (at least 48 states have in effect 124 such statutes; see App. L), these questions have great national significance. These are the kind of questions that the Supreme Court should resolve.

The questions in this case affect the operation of a vast number of employee health benefit plans; these plans provide

benefits for millions of employees and their dependents. The three appellants in this case alone have approximately 1,880,000 members entitled to benefits under their contracts and about 70% of these are under employee benefit plan contracts.[4] At September 30, 1984, there were 95 Blue Cross and Blue Shield Plans throughout the United States with approximately 79,000,000 subscribers. Of these, perhaps 65,000,000 were beneficiaries of employee benefit plans (including approximately 15,000,000 in multistate plans).[5] Most mandated-provider laws also apply to policies issued by life and health insurance companies to insure the health benefits in employee benefit plans. In Missouri alone over 800 health insurance companies offer health policies to employee groups. Thus by any quantitative measure the questions in this case are substantial.

There is yet another compelling reason for review by this Court in this case. In upholding the validity of these state statutes the Missouri Supreme Court relied upon two grounds that are contrary to the decisions of this Court. The Missouri court adopted a very narrow interpretation of when a state statute "relates to" an employee benefit plan; it also held that "Indirect regulation of employee benefit plans is permissible provided the regulation does not interfere with the purpose of ERISA." These rulings clearly conflict with the teachings of this Court in *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2890 (1983) and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

In summary, the questions presented by this case are substantial because (1) they are closely related to the questions in two other cases now before the Court, (2) their resolution will require an accommodation between two important federal

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[4] Some of these plans are not ERISA plans because of certain statutory exceptions and exemptions from ERISA coverage; the exact breakdown is not available.

[5] Source: Blue Cross and Blue Shield Association, Chicago, Illinois.

policies, (3) a very large number of people and companies will be directly affected by their resolution, and (4) the court below has failed to follow the clear doctrines announced by this Court.

B. The Challenged Statutes Are Preempted By ERISA Because They "Relate" To Employee Benefit Plans

(1) The statutes relate to employee plans

It is evident that these three mandated-provider statutes relate to employee benefit plans within the meaning of ERISA Section 514(a) because they have a significant impact on the content, cost, and administration of insured plans. The statutes apply to the group contracts issued by appellants and other insurers to the employee plans or to the plan sponsor for the purpose of providing the coverage selected in the plans. These contracts include a designation by the contracting parties of the class or classes of providers whose services will be paid for in treating the contingencies of illness or injury which are covered by the plans.

In the case of Blue Cross-Blue Shield organizations such as appellants, the insuring contracts are coupled with contracts appellants make with the class of providers designated in the insuring contracts to purchase the professional services needed to treat the health conditions covered by the plan contracts. The participating-provider contracts typically have cost-containment features and controls which enable appellants and other Blue Cross-Blue Shield organizations to deliver the contract service benefits at a more predictable, and lower, level of cost than would be possible without such arrangements.

Section 354.027 changes the contract terms negotiated and agreed upon for the employee group by requiring the appellants (and other health services corporations) to pay for the services of *any* type of licensed providers, if similar services would be paid for when furnished by the class of providers designated in the benefit plan contract. The statute overrides the selection of providers made by the parties to the plan contract.

Section 375.936(11)(b) has the same effect in overriding the provisions of the benefit plan contracts with appellants (and insurance companies) by requiring payment for the nine classes of providers named in that section.

Section 354.090-2 negates the anti-assignment provision in appellants' contracts with the employee plans by requiring appellants to pay pharmacists who have elected not to enter into participating contracts with appellants and who obtain an assignment from the beneficiary of his right to reimbursement. This affects the plan adversely because it enables the non-participating pharmacist to receive the benefit of participation, payments from appellants, without the cost controls and other obligations imposed by the contracts with providers.

The social merit of these mandated-provider laws is not in issue. The crucial fact is they affect ERISA plans: (i) they change the contract terms applicable to employee benefit plans; (ii) they increase the cost of treating the health conditions covered by the plans; (iii) they increase the cost of claims administration in multistate plans; (iv) they create variations instead of uniformity in the terms of multistate plans contrary to one of the key purposes of ERISA. The spectrum of types of providers whose services must be paid for under existing mandated-provider laws extends from certified social workers in Maryland to practitioners of "Oriental Medicine" in Nevada. (App. L) There are 15 classes of licensed practitioners under Missouri statutes alone whose members are eligible to be mandated providers under Section 354.027, including such occupations as ambulance drivers and attendants, optometrists, dental hygienists, speech pathologists, audiologists, practical nurses, and hearing aid fitters and dealers.[6]

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[6] RSMo § 334.010 (physicians and surgeons); RSMo § 336.020 (optometrists); RSMo § 331.030 (chiropractors); RSMo §332.081 (dentists); RSMo § 338.010 (pharmacists); RSMo § 330.020 (podiatrists);

That the Missouri legislature in enacting House Bill 127 intended it to relate to ERISA plans is shown by its provision that the addition of psychologists as mandated providers in Section 375.937(11)(b)

> "shall be effective January 1, 1984, and applied to contracts issued by health service corporations and insurance companies doing business in this state after such effective date, and to existing group contracts on the later of the next renewal date or the expiration of any *applicable colelctive bargaining contract, . . .*" (Emphasis supplied.)

The postponement of the effective date of the law for group contracts issued in connection with collective bargaining contracts is recognition by the legislature of the impact of the statute on the terms and administration of ERISA plans.

(2) The statutes should be held preempted by ERISA consistent with prior decisions of this Court

This Court's leading decisions on ERISA preemption, *Shaw v. Delta Air Lines, Inc.*, 103 S.Ct. 2890 (1983), and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), compel the conclusion that the Missouri Supreme Court erred in holding that these mandated-provider laws are not preempted because they do not relate to employee benefit plans, and because indirect regulation of such plans is permissible.

In *Shaw*, this Court emphasized the broad reach of ERISA's preemption of state laws that "relate to" employee benefit

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RSMo § 337.015 (psychologists); RSMo § 190.100(11) (mobile emergency medical technicians); RSMo 190.105 (ambulance attendants and attendant drivers); RSMo § 332.101 (dental hygienists); RSMo § 334.510 (professional physical therapists); RSMo § 335.016(5)(9) (professional nurses and practical nurses); RSMo § 345.020 (clinical audiologists); RSMo § 345.020 (professional speech pathologists); RSMo § 346.015 (hearing aid fitters and dealers).

plans. The Court noted the legislative history of Section 514(a) which demonstrates that "Congress used the words 'relate to' in § 514((a) in their broad sense" (*id.* at 2900). The Court expressly rejected the view, adopted by the Missouri court below, that only state laws which deal with the subject matters covered by ERISA are preempted. This Court wrote:

> "Nor given the legislative history, can § 514(a) be interpreted to pre-empt only state laws dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like. The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language. . ." (*id.* at 2900-2901).

Shaw confirmed the earlier conclusion of this Court in *Alessi* that ERISA's preemptive language prohibits state intrusion directly or indirectly upon this area "of exclusive federal concern." In *Alessi,* the Court ruled that a New Jersey law regulating the state's workers' compensation award by prohibiting an offset to pension benefits was preempted by ERISA, stating:

> "It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called "pension regulation." ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern. For the purpose of the pre-emption provision, ERISA defines the term "State" to include: "a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, *directly or indirectly,* the terms and conditions of employee benefit plans covered by this subchapter." 29 U.S.C.

§1144(c)(2) (emphasis added). ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." (*Alessi*, at 525).

The mandated-provider laws do precisely what *Alessi* held impermissible: they interfere with the discretion ERISA gives employee benefit plan designers to select the terms and conditions of the plans, free from state intrusion. The laws intrude by ordering the contracting parties to pay for services of providers they do not want. A primary objective of Congress in enacting ERISA, the elimination of the threat of conflicting and inconsistent state and local regulation of employee benefit plans, is defeated by these laws, which vary from state to state and prevent uniformity in the operation of multistate benefit plans (see *Shaw*, at 2900-2901, 2904).

C. The Mandated-Provider Statutes Are Not Excepted From ERISA Preemption As "Regulation Of Insurance" Because The Activities Regulated By Those Sections Do Not Satisfy The Court's Criteria For "Insurance".

There remains the question whether these mandated-provider laws, although relating to ERISA plans, are saved from preemption by the exception for any state law "which regulates insurance . . ." (Section 514(b)(2)(A); 29 U.S.C. 1144(b)(2)(A). The court below ruled that the insurance exception applies because the appellants are treated by Missouri law as in the "business of insurance" for certain purposes, because they "are in competition with insurance companies", because they accept premiums from customers in exchange for payment of future expenses and because they spread risks. The court concluded "that plaintiffs [appellants] are within the insurance exemption of ERISA for purpose of state regulation" (Appendix A).

The state court erred by confusing the regulation of insurance companies with the regulation of insurance. It focused its atten-

tion on the status of the entities regulated by these Missouri laws, health services corporations and insurance companies, instead of on the specific activities regulated by the statutes, namely, the selection of practitioners for whose services plan beneficiaries are entitled to be reimbursed.

ERISA's preemption and insurance savings clauses should be interpreted consistently with the McCarran-Ferguson Act's exemption of the "business of insurance" from federal antitrust laws (15 U.S.C. 1012(b)) because the similar provisions in the two statutes have the same purpose, reserving to the states the authority to regulate insurance. But the Missouri court's reasoning and result are contrary to established McCarran-Ferguson principles for defining "insurance" in the context of that Act's exemption of the "business of insurance". Recent decisions of this Court state the criteria for determining activities constituting "insurance" whose regulation Congress has left to the state: The state laws must deal with activities (1) which transfer and spread the risk of loss; (2) which directly affect the relationship between the insurer and its policy holders; and (3) which are confined to entities within the insurance industry. See *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *Union Labor Life Insurance Co. v. Pireno*, 102 S.Ct. 3002 (1982), *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969).

The activities regulated by the Missouri laws in the present case—selection of the classes of providers to be paid for services to insureds—do not come within these criteria for "insurance". It follows that the challenged laws do not "regulate insurance" so as to be saved from preemption by Section 514(b)(2)(A) of ERISA.

In *Royal Drug, supra*, the Court had the question whether agreements between a Blue Shield organization and certain pharmacies constituted the "business of insurance" within the meaning of McCarran-Ferguson. The agreements were

participating-provider arrangements under which selected pharmacies agreed to sell prescription drugs to policyholder members at a fixed mark-up over the pharmacies' costs. Policyholders using the participating pharmacies paid only the fixed amount of the mark-up with the balance billed directly to the insurer for payment. Policyholders could use non-participating pharmacies but in such case received lower coverage and deferred reimbursement.

In rejecting the claim of McCarran-Ferguson Act exemption, the Court held that the challenged provider arrangements were not the "business of insurance" even though they implemented an insurance contract and were entered into by insurers regulated by state law. The Court adopted the textbook[7] definition that the essence of insurance is the transfer and spreading of the risk of a future occurrence from the insured to the insurer. The Court reasoned that the provider arrangements did not operate to spread risk— an "indispensible characteristic of insurance", 440 U.S. at 212. Because the insurer was already obligated to pay for the covered drug benefits, the agreements with the pharmacies served only to reduce the insurer's cost. In this respect, they did not "involve any underwriting or spreading of risk, but are merely arrangement for the purchase of goods and services by Blue Shield." (*id.* at 214).

The Court's conclusion was reinforced by consideration of two other criteria for "insurance": the pharmacy agreements were not an integral part of the relationship between the insurers and their policyholders, and the arrangements involved parties who were outside the insurance industry (*id.* at 215-217, 231-233).

In *Union Labor v. Pireno, supra,* the Court applied the same definition of the "business of insurance" to reject the claim of a

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[7] The Court cited, 1 G. Couch, *Cyclopedia of Insurance Law* #1.3 (2d Ed. 1959); R. Keeton, *Insurance Law* #1.2a (1971), 1 G. Richards, *The Law of Insurance,* #2 (W. Freedman 5th ed. 1952).

Blue Shield organization that its use of peer review practice was exempt from antitrust challenge under the McCarran-Ferguson Act. The Court referred to the three criteria identified in *Royal Drug* for determining whether a particular practice is part of the "business of insurance":

> "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry . . . ." (*id.* at 3009).

The Court concluded that the arrangements for peer reviews, although related to the insurance contract, did not satisfy these criteria for insurance.

In the earlier case of *SEC v. National Securities*, supra, the Court rejected a claim of McCarran-Ferguson Act exemption for the business of insurance, pointing out that the exemption does not refer to persons or companies who are subject to state regulation, but to the regulation of specific *activities* which are within the business of insurance (*SEC*, at 459-460). As previously noted, the court in the present case failed to make this distinction between a law regulating insurance companies and a law regulating "insurance".

Application of these principles demonstrates that the Missouri mandated-provider sections, and similar laws in many states, are not within the core of state regulation of the "business of insurance" under the McCarran-Ferguson Act and, by close analogy, are not the regulation of "insurance" for the purpose of the insurance exception to ERISA preemption.

(1) Designating providers whose services are to be paid for does not transfer or spread risk

First, and most important, the regulation of the type of providers whose services will be paid for has nothing to do with the

transfer and spreading of risk, which this Court identified as an "indispensible characteristic of insurance." (*Royal Drug*, at 212.) By requiring that appellants and other insurers pay for the services of specified practitioners, these statutes do not shift the risk of occurrence of illness or injury from the policyholder to the insurer. As in the case of the pharmacy provider agreements in *Royal Drug* and the peer review procedures in *Union Labor*, the appellants are already obligated under their group contracts to pay for professional services needed to treat a covered health condition. The risk insured against—the loss resulting from the occurrence of illness or injury requiring the services of a health practitioner—is transferred from the insured to the appellants at the time the group contract is formed.[8] At the same time, the appellants accept a similar risk for each member of the insured group, thereby spreading the potential loss over all the risks assumed, in exchange for the agreed premiums.

The transfer and spreading of risk are completed before the mandated-provider laws affect the transaction. The statutory requirement that the insurer pay for certain classes of practitioners does not transfer or spread any risk because it operates only *after* the risk has been transferred to the insurer, and after the insured contingency of illness or injury has occurred. As observed by this Court in *Royal Drug*, the provider agreements "do not involve any underwriting for the purchase of goods and services by Blue Shield", (*Royal Drug* at 214), and "serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations." (*Royal Drug* at 213).

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[8] The risk transferred in a health insurance contract does not include whether the insured will choose a particular type of provider to treat the covered health condition. A basic principle of insurance is that the risk transferred under any insurance policy is a specified event out of the control of the insured and the insurer, and one that is disadvantageous to the insured. See 1 *Couch on Insurance*, 2d, §2.7, at 286-287 (Rev. ed. 1984). The risk "relate[s] to a possibility of real loss which neither the insured nor the insurer has the power to avert or hasten." (*Id.* at 287). As the choice of providers is within the control of the insured once the policy is issued, it is not an insurable risk.

The Court of Appeals for the Fourth Circuit in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia,* 624 F.2d 476 (1980) also recognized the distinction between the choice of providers to be paid after the contingency has occurred and the risk assumed by the insurer at the formation of the contract. The case involved a Blue Shield Plan that agreed to pay for the services of a psychologist in treating the insured only if those services were billed through a physician. The court, in ruling that the "business of insurance" exemption from the antitrust laws does not apply to such arrangement, said Blue Shield's "decision regarding psychologists was not whether to underwrite the risk of those disorders or even the need for psychotherapy; rather it was a question of who they would pay for such services. The coverage remained the same." (624 F.2d at 484).

The analysis by the court in *Virginia Academy* is equally applicable here because the sections in issue do not change the risks which are underwritten or add to the contract coverage. The laws affect only what type of practitioners' services will be paid for treatment of the covered disorder, and whether nonparticipating pharmacists are entitled to direct payment. The prior decisions of this Court lead to the conclusion that these mandated-provider laws are not the "regulation of insurance" because they regulate activities which lack "the indispensible characteristic of insurance."

(2) The arrangements for provider services are not an integral part of the insurance relation.

The same conclusion is reached when the mandated-provider laws are tested by the second criterion for insurance relied upon by the Court: whether the regulated activity is an integral part of the relationship between the insurer and the insured. (*Union Labor,* at 3009). Mandated-provider laws regulate the insurer's relationship, not with its insureds, but with providers of covered health services by requiring payment for services of certain types of practitioners.

In *National Securities, supra,* the question was whether a state law that governed the merger of two insurance companies was a law regulating the business of insurance under McCarran-Ferguson. If the state law regulated the business of insurance, the federal securities laws did not apply to the merger of the companies.

The Court noted that Congress, in enacting the McCarran-Ferguson Act, was concerned primarily with the relationship between the insured and the insurer, "with the type of state regulation that centers around the contract of insurance . . ." (393 U.S. at 460). In applying this criterion, the Court determined that the state's regulation of the merger was regulation of the relationship between the insurance company and its stockholders; therefore, it was not insurance regulation (*id.* at 460, 463). The Court dismissed, as form over substance, the argument (also used by the court below in the present case) that the law regulated the business of insurance because it applied only to insurance companies (*id.* at 459-460).

In *Royal Drug,* the Court discussed the fact that the pharmacy provider agreements affect the insured's choice of pharmacy and the extent and manner of reimbursement for the prescription drug benefit covered by the insurance policy. Nevertheless, the Court characterized this as tangential to the insurance issue, stating:

> "The Pharmacy Agreements are not "between insurer and insured." They are separate contractual arrangements between Blue Shield and pharmacies engaged in the sale and distribution of goods and services other than insurance." (*Royal Drug* at 216)

The activities regulated by the mandated-provider laws are no more an integral part of the relationship between the insured and the insurer than were the pharmacy agreements in *Royal Drug*. In either context, the insured's selection of a practitioner is affected by economic incentives but those commercial ar-

rangements for provision of the contract services are outside the basic insured-insurer relationship.

(3) The statutes involve persons outside the insurance industry.

The third criterion used by the Court is whether the practice regulated by the statute is limited to entities within the insurance industry. Again, these mandated-provider laws fail the test for regulation of insurance because they have a direct, intended effect upon persons wholly outside the insurance industry, namely the providers in the various licensed occupations listed or embraced by the statutes. This Court in both *Royal Drug* and *Union Labor* concluded that the providers of services incident to these contracts were "wholly outside" the insurance industry and that the arrangements with the providers in issue in those cases were not part of the business (440 U.S. at 231; 102 S.Ct. at 3009). Application of this test to mandated-provider laws also leads to the conclusion that such laws do not regulate insurance because they involve parties outside the insurance industry. The laws compel payments for services of persons who have no connection with the insurance business.

Mandated-provider laws fail to meet each of the three criteria which this Court has used in determining whether a state law is a regulation of insurance.

CONCLUSION

The analyses used by this Court in *Royal Drug* and *Union Labor* in determining that arrangements between insurers and providers are not part of the business of insurance for purpose of the McCarran-Ferguson Act exemption from antitrust laws apply precisely to the questions in this case. The activities regulated by the statute in issue are not part of insurance for the same reasons. It would be anomalous to find that although contracts between insurers and providers are not part of the business of insurance under one federal statute, these

mandated-provider laws which supplant such contracts are the "regulation of insurance" under another federal statute which tracks the pertinent language of the prior law.

Probable jurisdiction should be noted.

Respectfully submitted,

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April 15, 1985

APPENDIX

APPENDIX A

SUPREME COURT OF MISSOURI

En Banc

No. 65881

Blue Cross Hospital Service, Inc. of Missouri, et al.,
Plaintiffs-Respondents/
Cross-Appellants,

v.

J. H. Frappier, Director, Department of Consumer Affairs, et al.,
Defendants-Respondents,

The Missouri Psychological Association, a Missouri not-for-profit corp.,
Intervenor-Defendant/
Respondent,

Missouri Pharmaceutical Association, et al.,
Intervenors-Defendants-
Appellants/Cross-
Respondents.

APPEAL FROM THE CIRCUIT COURT OF COLE COUNTY

Honorable James F. McHenry, Judge

(Filed Dec. 18, 1984)

The plaintiffs are health service corporations organized under Chapter 354, RSMo 1978. Plaintiff Blue Cross and Blue Shield of Kansas City has 450,000 members; plaintiff Blue Cross Hospital Service, Inc. of Missouri has 780,000 members and plaintiff Missouri Medical Service has 650,000 members.

The plaintiffs provide payment for medical care incurred by subscribing members. They make payment directly to providers and maintain separate contractual agreements with subscribers and health care providers. By contrast, commercial insurers customarily reimburse policyholders directly. Plaintiffs claim that this arrangement allows them some control over the charges of health care providers.

In 1983 the General Assembly in a single bill adopted an addition to § 375.936(11)(b), RSMo 1978 and also amended Chapter 354. The amendments, among other things, forbade health service corporations to discriminate against chiropractors and psychologists, which plaintiffs had refused to pay as a matter of policy. The plaintiffs claim unconstitutionality, both as to the legislative procedures and the substantive effects of the statute.

House Bill 127 as introduced had the following title:

> An Act to repeal section 375.936 RSMo 1978, relating to the definition of unfair practices in the business of insurance, and to enact in lieu thereof one new section relating to the same subject. [Plaintiffs' Exhibit 1.]

Its only effect was to add the word "psychologist" to the practitioners listed in subsection 11(b).

Section 375.936 had been in force since 1959. One of its purposes was to prohibit "unfair discrimination" by insurance companies among providers of health care. The section had not been applied to health service corporations until 1978. In the course of its journey through the General Assembly, portions of other bills were combined with House Bill 127. The bill, as

finally adopted, contained 94 new sections relating to Chapter 354 corporations. The title was broadened to make express reference to the regulation of health service corporations.

The plaintiffs' petition charged that House Bill 127 was unconstitutional, asserting that: (1) the amendments during passage changed its original purpose in violation of Art. III, § 21 of the Missouri Constitution; (2) the bill deals with more than one subject, the content of which is not clearly expressed in the title, as required by Art. III, § 23; (3) the bill impairs the obligation of contracts in violation of Art. I, § 13 of the Missouri Constitution and Art. I, § 10 of the United States Constitution; (4) the bill violates the due process clauses of the federal and state Constitutions; (5) the bill deprives persons in the position of plaintiffs of equal protection of laws in violation of the Fourteenth Amendment; and (6) the provisions of the bill are preempted by ERISA, 29 U.S.C. § 1001, *et seq.*

The trial court found for the plaintiffs on grounds (1) and (2) specified above, and found it unnecessary to pass on the remaining grounds alleged. Both parties appeal, the plaintiffs contending that the court should have declared the statutes invalid under ERISA. We conclude that none of the reasons assigned for invalidity has merit, and so reverse the judgment and remand with directions to declare the statute valid as against the challenges tendered.

1. Legislative History

Statutes are presumed to be constitutional. State v. Newlon, 627 S.W.2d 606 (Mo. banc 1982), *cert. denied* 459 U.S. 884 (1982). In the leading recent case on the permissible scope of amendments during the course of legislation, Westin Crown Plaza Hotel Co. v. King, 664 S.W.2d 2 (Mo. banc 1984), this Court upheld the validity of a statute with a history similar to that of the statute now before us. House Bill 127, in its original

form, prohibited insurance companies and health service corporations from discriminating against psychologists. Amendments were later added that provided broader anti-discriminatory measures. The amendments did not constitute a substantial departure from the original anti-discriminatory purpose. Amendments germane to the initial bill do not change its original purpose. State v. Ludwig, 322 S.W.2d 841 (Mo. banc 1959). Art. III, § 21 was not designed to inhibit the normal legislative processes, in which bills are combined and additions necessary to comply with the legislative intent are made. The plaintiffs have not met their rather substantial task of showing that the legislative history rendered the statute unconstitutional.

Plaintiff relies on Allied Mutual Ins. Co. v. Bell, 185 S.W.2d 4 (Mo. 1945). This Court held that a statute was unconstitutional because it introduced a tax which was not within the purpose of the original bill. The Court emphasized that the original purpose of the bill was not included in the law as passed. The original House Bill 127 remained part of the final House Bill 127. The general purpose of the bill was not changed, but rather additions were made. The modification of the title to reflect the added provisions is permissible. Lincoln Credit Co. v. Peach, 636 S.W.2d 31 (Mo. banc 1982).

The title, also, is not constitutionally infirm. The title of the original House Bill 127 read as follows:

> An Act to repeal section 375.936 RSMo 1978, relating to the definition of unfair practices in the business of insurance, and to enact in lieu thereof one new section relating to the same subject. [Plaintiffs' Exhibit 1.]

The title of the revised bill is as follows:

> An Act to repeal sections [listing sections] relating to the regulation of certain corporations and other organizations which provide services or coverage for certain health

related risks, and to enact in lieu thereof ninety-five new sections relating to the same subject. [Plaintiffs' Exhibit 4]. [Section numbers omitted].

We believe that the title fairly describes the subject matter of the adopted bill. A title need not give specific details of a bill. An announcement of the general subject matter is sufficient to give notice of the bill's content. Downey v. Schrader 182 S.W.2d 320 (Mo. banc 1944), Edwards v. B.M.A., 168 S.W.2d 82 (Mo. 1942). The purpose of the "one subject" mandate is to give interested persons notice of tne area of regulation to prevent deception through use of misleading titles, and to maintain the concept of germaneness. This requirement is satisfied if the title is sufficient to alert persons interested in the subject matter. Union Electric Co. v. Kirkpatrick, 606 S.W.2d 658 (Mo. banc 1980). The original title clearly applied to plaintiffs, for Section 375.932(3) provides that § 375.936 applies to Chapter 354 corporations. Plaintiffs had the opportunity for notice, at that point, that the bill was pending. The amended title clearly refers to the regulation of health service corporations and all of the added sections are germane to this regulation. The test is whether all provisions of the bill fairly relate to the subject expressed in title, have natural connections therewith or are incidents or means to accomplish the expressed purpose. Westin Crown Plaza Hotel Co. v. King, *supra*. The title gave the public adequate notice that health service corporations were to be regulated.

2. Substantive Constitutional Provisions

The plaintiffs fail to demonstrate any unconstitutional impairment of their contracts. A law which affects a contract does not necessarily violate Art. I, § 13 of the Constitution of Missouri and Art. I, § 10 of the Constitution of the United States. Private executory contracts are not immune from the valid exercise of the police power, and persons cannot oust the

state of its police power by making long-term contractual arrangements. State ex rel. Kansas City v. Public Service Commission, 524 S.W.2d 855 (Mo. banc 1975). The police power exists to promote the public health, safety and welfare. Providing freedom of choice as to health care providers is clearly within the scope of this power. An exercise of the police power is valid if the objective is proper and the means adopted to accomplish that object are rationally related to the end sought. Missouri Dental Board v. Alexander, 628 S.W.2d 646 (Mo. banc 1982). Forbidding health service corporations from discriminating against certain health care providers is a rational method of ensuring freedom of choice in the health care market.

Plaintiff cites Ketcham v. King County Medical Service Corp., Wash., 502 P.2d 1197 (1972), as authority that this type of "freedom of choice" statute unconstitutionally impairs contracts. We disagree with the logic of that decision. The Washington court viewed the purpose of the statute to be one of taking benefits from one class of providers and giving them to another. The opinion also revealed a strong bias against optometrists. The primary purpose of House Bill 127, as we see it, is to provide freedom of choice among health care providers. This is a matter of importance to the public health which falls within the police power of the state.

The test of substantive due process is met if a statute has a rational relationship to a legitimate state interest. United States v. Caroline Products Co., 304 U.S. 144, 58 S.Ct. 778, 82 L.Ed. 1234 (1938). There is an obvious state interest in providing freedom of choice for health care consumers, and the statute bears a rational relationship to that interest. State policies are for the legislature to decide and legislative decisions should be reversed only upon a clear showing of unconstitutionality. Plaintiffs' due process argument has no merit.

Plaintiffs claim a violation of the equal protection clause of the Fourteenth Amendment because §§ 354.027 and 354.090.2

apply only to health service corporations. Section 354.027 provides that such corporations must pay any licensed provider even though the corporation has no contract with the provider. Commercial insurance companies generally do not have provider contracts, and a provision of this kind is not necessary in the regulation of these companies. Section 375.936(11)(b) prevents insurance companies from discriminating against an extensive list of licensed providers in the provision of policy benefits. Section 354.090.2 would compel plaintiffs to recognize the assignment of membership benefits to a pharmacist as valid. Commercial insurance companies would not ordinarily discriminate among pharmacists because they do not usually make payments to pharmacists, and plaintiffs fail to demonstrate that this section places them at a invidious disadvantage.

The equal protection clause guarantees equal treatment for all who are similarly situated but does not forbid a state from creating classes in the adoption of regulations under its police power. City of St. Louis v. Liberman, 547 S.W.2d 452 (Mo. banc 1977). The state may validly regulate health service corporations in a manner differing from the regulation of commercial insurers. The two are organized under different chapters of the state code. Each provides insurance by different methods. Plaintiffs' own witness testified that there is a rational basis for treating health service corporations in a different way. The statutes contain several chapters, each applying to a different class of insurer, and the provisions show substantial variation. Plaintiffs are not members of a suspect class, nor does the statute involve fundamental personal rights. Plaintiffs, there fore, have the burden of showing that any distinction is purely arbitrary. Such a showing has not been made. When the substantial differences between nonprofit hospital and medical service corporations and commercial insurance carriers are considered, the legislature, in exercising its police power may

classify non-profit corporations as separate from commercial insurers. Hospital Service Corp. of Rhode Island v. West, 308 A.2d 489 (R.I. 1973). With this power goes the authority to regulate the industries differently if the regulation is reasonable.

On this point, plaintiff again relies on a decision from another state. Blue Cross v. Commonwealth of Virginia, 269 S.E.2d 827 (1980). An anti-discrimination statute exempted commercial insurance companies from 1973 until 1979. Missouri already had a statute, § 375.936(11)(b), prohibiting discrimination by commercial insurers. The statute does not impose an onerous burden on the plaintiff. We also disagree with the Virginia Court's holding that there are no differences between health service corporations and commercial insurers which justify differing regulation.

3. ERISA Preemption

Plaintiffs' final argument is that House Bill 127 is preempted by certain provisions of ERISA, 29 U.S.C. § 1144. ERISA, however, excepts "any law of any state which regulates insurance ..." 29 U.S.C. § 1144(b)(2)(A).

The plaintiffs argue that health service corporations are not engaged in the "business of insurance." Our legislature in § 375.947 has decreed otherwise, in regard to the anti-discrimination statutes involved in this case. The plaintiffs admit that they are in competition with insurance companies. They accept a predetermined premium from customers, in exchange for payment of future medical expenses. The spreading of risk, as practiced by plaintiffs, is the hallmark of insurance. The insurance exemption contained in the McCarran Ferguson Act, 15 U.S.C. § 1012(b), is not identical to the exemption for state laws regulating insurance contained in ERISA. The McCarran Ferguson Act grants exemption from the federal antitrust laws which declare a strong national policy, and the ex-

emption should be grudgingly applied. Group Life & Health Ins. Co. v. Royal Drug, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979).

Plaintiffs contend that McCarran Ferguson cases are authoritative in construing preemption clause contained in ERISA. ERISA gives specific permission to the states to regulate insurance, and the states should be permitted to determine the scope and extent of the desired regulation. Congress, furthermore, specifically enumerated certain entities which are not to be considered insurance companies for ERISA preemption. 29 U.S.C. § 1144(b)(2)(B). Health service corporations were not included in this group. We believe that plaintiffs are within the insurance exemption of ERISA for purposes of state regulation.

We are not convinced, in any event, that, aside from the insurance exemption, the challenged legislation is preempted by ERISA. ERISA preempts any state law relating to employee benefit plans. Shaw v. Delta Airlines, Inc., 103 S.Ct. 2890, 463 U.S. ____, 77 L.Ed.2d 490 (1983). The statute in question does not relate to employee benefit plans. It prohibits health service corporations from engaging in certain discriminatory practices. Nothing is required of an employee benefit plan. The plan may provide, or not provide, any bargained for service. A self-insured plan is free to discriminate among providers. Commercial insurers, however, may not discriminate among licensed providers. This Court previously held there is no indication in the legislative history of ERISA that Congress intended to preempt areas of state regulation not addressed by ERISA. Electrical Workers, Local No. 1, Credit Union v. IBEW-NECA Holiday Trust Fund, 583 S.W.2d 154 (Mo. banc 1979). Indirect regulation of employee benefit plans is permissible provided the regulation does not interfere with the purpose of ERISA. ERISA is intended to establish minimum standards and

safeguards for private pensions while maximizing the freedom of decision making by employers and employees. H.R. Rep. No. 533, 93 Cong. 2d Sess., reprinted in 1974 USCCAN 4639. Nothing in House Bill 127 conflicts with these purposes.

Our holding is consistent with Wadsworth v. Whaland, 562 F.2d 70 (1st Cir. 1977) *cert. denied* 435 U.S. 980 (1978) (opinion by Judge Lay of the Eighth Circuit). That Court held that a state statute requiring the issuers of group health insurance policies to provide coverage for the treatment of mental illnesses and emotional disorders was not preempted by ERISA, simply because group health insurance is a part of many employer benefit plans. Judge Lay observed that a contrary holding would frustrate the insurance exemption to the preemptive provisions of ERISA.

Also consistent is Attorney General v. The Travelers Insurance Co., 391 Mass. 730, 463 N.E.2d 548 (1984), decided by the Supreme Judicial Court of Massachusetts, following remand from the Supreme Court of the United States for reconsideration in the light of Shaw v. Delta Airlines, Inc., *supra.* The Massachusetts court held that a provision for mandatory mental health benefits in policies of accident and sickness insurance, including expressly "any employees' health and welfare fund," was a regulation of "insurance" and therefore not preempted by ERISA. The case has been taken by appeal to the Supreme Court of the United States and has been set for oral argument. 53 U.S.L.W. 3295, 3323 (1984). This case is perhaps a stronger one for allowing state regulation than the Massachusetts case, because there is no specific reference in our statute to employees' health and welfare funds.

The judgment of the circuit court is reversed and the case is remanded with directions to enter a judgment declaring that House Bill 127 is not unconstitutional for the reasons assigned by plaintiffs.

Charles B. Blackmar, Judge

Rendlen, C.J., Higgins, Gunn, and Billings, JJ., concur; Welliver, J., dissents in separate opinion filed; Donnelly, J., dissents in separate opinion filed.

SUPREME COURT OF MISSOURI

En Banc

No. 65881

Blue Cross Hospital Service, Inc. Of Missouri, et al.,
Plaintiffs-Respondents/
Cross-Appellants,

v.

J. H. Frappier, Director, Department of Consumer Affairs, et al.,
Defendants-Respondents,

The Missouri Psychological Association, a Missouri not-for-profit corp.,
Intervenor-Defendant/
Respondent,

Missouri Pharmaceutical Association, et al.,
Intervenors-Defendants-
Appellants/Cross-Respondents.

DISSENTING OPINION

(Filed Dec. 8, 1984)

I respectfully dissent. I would affirm the judgment of the circuit court on the ground that the legislation challenged in this proceeding violated the prohibitions of Sections 21 and 23, Mo. Const. art. III, thereby making it unnecessary to reach the questions of due process, equal protection and impairment of contract.[1]

The practice of taking a bill that appears doubtful of passage and combining it with a bill or bills reasonably assured of passage and passing the resulting bill under a broad and general amended title is one of the most expeditious and effective legislative strategies. It is also one of the most deceptive. This is the precise practice that Sections 21 and 23 seek to prohibit.

It is no secret that since courts began holding that Blue Cross-type hospital and medical service plans were not insurance,[2] almost every session of the General Assembly has been faced with bills seeking to regulate Blue Cross as an insurance company. In my opinion, H.B. 127, 82nd General Assembly, effectively accomplishes via the back door that which could never be accomplished via the front door, i.e., legislative—judicial conversion of Blue Cross into a regulated insurance company. I re-

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[1] The principal opinion appears to rely on Missouri Dental Board v. Alexander, 628 S.W.2d 646 (Mo. banc 1982) as authorizing any impairment of the contracts herein under the police power. It was there stated that "The record is void of any evidence that appellants are parties to any executory contracts entered into prior to enactment of these statutes and affected by enactment of these statutes. Article I, § 13 prohibits the state from enacting statutes which impair the rights of parties to any *existing* contract." *Id.* at 652. If anything, it would seem to suggest the contrary.

[2] *See* Jordan v. Group Health Association, 107 F.2d 239 (D.C. Cir. 1939); California Physicians' Service v. Garrison, 172 P.2d 4 (Cal. 1945); Commissioner of Banking & Insurance v. Community Health Service, 30 A.2d 44 (N.J. 1943); State ex rel. Fishback v. Universal Service Agency, 87 Wash. 413, 151 P. 768 (1915). *See generally,* Annot. 167 A.L.R. 322 (1946).

main firmly convinced that courts must strictly enforce Sections 21 and 23 of art. III of our Constitution if we are to maintain "the integrity of and public confidence in both the legislative process and our system of judicial review." Westin Crown Plaza Hotel Co. v. King, 664 S.W.2d 2, 7 (Mo. banc 1984) (Welliver, J., dissenting).

Most who deal with third party payment of hospital and medical services are aware that Blue Cross-type plans have fought a last ditch battle to contain rising hospital and medical costs. Simply stated, they have done so by reason of their unique contract with their members which enabled them to offer and hold out to participating hospitals and physicians the offer of direct payment of pre-agreed fees for services, leaving the non-participating and the higher chargers to fend for themselves in collection of their charges. My concern now is where in insurance law or regulations or standard insurance contracts will there be found any authorization to so resist rising medical costs. More likely, such action would be viewed as vexatious delay in the payment of insurance claims.

I would affirm the judgment of the circuit court.

Warren D. Welliver, Judge

SUPREME COURT OF MISSOURI

En Banc

No. 65881

Blue Cross Hospital Service, Inc.
Of Missouri, et al.,
Plaintiffs-Respondents/
Cross-Appellants,

v.

J. H. Frappier, Director,
Department of Consumer Affairs,
et al.,
Defendants-Respondents,

The Missouri Psychological
Association, a Missouri not-for-
profit corp.,
Intervenor-Defendant/
Respondent,

Missouri Pharmaceutical
Association, et al.,
Intervenors-Defendants-
Appellants/Cross-
Respondents.

DISSENTING OPINION

(Filed Dec. 18, 1984)

On this appeal, we must weigh an exercise of the police power of Missouri against the provision "[t]hat no law * * * impairing the obligation of contracts * * * can be enacted." Mo. Const. art. I, § 13.

In State ex rel. Kansas City v. Public Service Commission, 524 S.W.2d 855, 864 (Mo. banc 1975), this Court said:

> The rule we adopt recognizes that the police power is essential to the achievement of such objectives as protecting the health and safety of the public and that it is as broad as need be to achieve those objectives. At the same time, it recognizes that the police power is not so powerful that it impairs the obligations of contracts where such impairment is not necessary to achievement of the objective for which the power is being exercised.

The issue on this appeal is whether, as defendants contend, the addition of the word "psychologist" to the list of health providers is necessary for protection of the public health and welfare.

"In discussing this question, [the principal opinion] * * * assumes the inevitability of an affirmative answer. It does not in any manner demonstrate that if [psychologists are not added to the list] * * *, the protection of the public [health and welfare] * * * by means of the police power will be frustrated or even hindered." *State ex rel. Kansas City, supra,* at 860.

In my view, the challenged statute violates our Missouri Constitution. It unconstitutionally impairs the obligation of contracts. Mo. Const. art. I, § 13. We need not address the similar provision in Article I, § 10 of the United States Constitution. *See* Allied Structural Steel Co. v. Spannaus, 438 U.S. 234 (1978).

I respectfully dissent.

Robert T. Donnelly, Judge

APPENDIX B

IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI
NINETEENTH JUDICIAL CIRCUIT

Case No. CV183-864CC

Blue Cross Hospital Service, Inc. of Missouri, a Missouri not for profit corporation,

Missouri Medical Service, a Missouri not for profit corporation,

and

Blue Cross and Blue Shield of Kansas City, a Missouri not for profit corporation,

Plaintiffs,

v.

J.H. Frappier, Director of the Department of Consumer Affairs, Regulation and Licensing for the State of Missouri,

and

C. Donald Ainsworth, Director of the Division of Insurance for the State of Missouri,

Defendants,

and

The Missouri Psychological Association, a Missouri non-for-profit corporation,

and

Missouri Pharmaceutical
Association, Inc., a Missouri
non-for-profit corporation,

and

M. Earl Cash,
Defendants - Intervenors.

DECLARATORY JUDGMENT AND PERMANENT INJUNCTION

(Filed Feb. 27, 1984)

Now on this 27th day of February, 1984, the Court, having issued under the date of November 23, 1983, a temporary injunction against defendants in this cause, which was heard on October 31, 1983, and thereafter upon the submission of this cause upon its merits by the parties hereto, the Court, upon the pleadings and proof adduced and upon the briefs presented by counsel, being fully advised in the premises, makes the following findings:

1. That this Court has jurisdiction to hear this cause and enter the judgment and orders contained below; and

2. That plaintiffs are duly authorized health services corporations under Chapter 354, RSMo 1978, and as such, have the power to bring this cause; and

3. That there exists a justiciable controversy ripe for judicial decision for which plaintiffs have standing to assert; and

4. That Senate Substitute for Senate Committee Substitute for House Bill 127, as Truly Agreed to and Finally Passed by the 82nd Missouri General Assembly, First Regular Session, on June 30, 1983, and as signed by the governor on July 28, 1983, (hereinafter referred to as HB 127, unless otherwise noted), contains subject matter which was added during the process of its passage which does not naturally, legitimately and germanely

relate to the subject matter of the bill as originally introduced, and said bill as passed does not contain one subject clearly expressed in the title; and

5. That HB 127 was enacted in contravention of Article III, Sections 21 and 23, of the Constitution of Missouri, in that such bill was amended in its passage so as to change its original purpose, and in that the bill contains more than one subject matter not clearly expressed in the title, except as mentioned below; and

6. That Section 375.936 of HB 127, as passed, is within the scope of the original purpose of HB 127, as originally introduced, and, therefore, it is not constitutionally invalid as being in contravention of Article III, Section 21 or 23, of the Constitution of Missouri; and

7. That Section 375.936 of HB 127, as passed, is severable from the constitutionally invalid provisions contained in the bill because it is not so essentially and inseverably connected with and dependent upon the constitutionally invalid provisions that it cannot be presumed that the General Assembly would not have enacted Section 375.936 without the invalid provisions, and that Section 375.936 of HB 127, standing alone, is capable of being enforced without the invalid provisions, all pursuant to Section 1.140, RSMo 1978; and

8. That plaintiffs would suffer irreparable harm to their operations not compensable with money damages in the event that defendants, or their successors, agents or employees, would enforce the constitutionally invalid provisions of HB 127, as stated above, and compel plaintiffs to comply therewith; and

9. That plaintiffs have no adequate remedy at law.

10. As the findings made in paragraph 5 with respect to Counts I and II of the petition are applicable to invalidate all parts of HB 127 as passed except Section 375.936(11) thereof, it is not necessary to decide the issues raised in Counts III, IV, V and VI as to all such parts held invalid.

11. Plaintiffs' claim that Section 375.936(11) of HB 127 as passed is preempted by the provisions of the Employees Retirement Income Security Act of 1974, (ERISA), 29 U.S.C. Section 1001, *et seq.*, is not supported by the evidence contained in the record such that a finding on such issue can be made by this Court which would resolve or eliminate a pending controversy between the parties.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED, as follows:

1. That Senate Substitute for Senate Committee Substitute for HB 127, as Truly Agreed to and Finally Passed by the 82nd Missouri General Assembly, First Regular Session, 1983, is hereby declared and adjudged to be unconstitutional, invalid and void, with the exception of Section 375.936 thereof, which section is declared to be severable and not in violation of Article III, Sections 21 and 23 of the Constitution of Missouri.

2. That defendants, their successors, agents and employees, and all others claiming authority under the terms of HB 127, as passed, are hereby permanently enjoined and restrained from enforcing and carrying out the provisions of HB 127 as passed, with the exception of Section 375.936, RSMo 1978 (as amended), including the performance of any functions or the taking of any action incident to the administration of the bill, collection of fees, enforcement of the bill or promulgation of regulations premised upon HB 127, as passed.

3. That the bond filed herein by plaintiffs is hereby released, and plaintiffs and their surety are discharged therefrom.

4. Costs are taxed to the following defendants - intervenors: Missouri Pharmaceutical Association, Inc. and M. Earl Cash.

/s/ James F. McHenry
Circuit Judge

APPENDIX C

CLERK OF THE SUPREME COURT
STATE OF MISSOURI

Post Office Box 150
Jefferson City, Missouri
65102

Thomas F. Simon
Clerk

Telephone
(314) 751-4144

January 15, 1985

Mr. Michael Dallmeyer
234 E. High Street
Jefferson City, Missouri 65101

Mr. Henry J. Mohrman
714 Locust
St. Louis, Missouri 63102

Mr. Max O. Bagby
Commerce Tower, Suite 2330
Kansas City, Missouri 64105

Mr. Robert F. Schlafly
314 N. Broadway
St. Louis, Missouri 63102

In re: Blue Cross Hospital Service, Inc. of Mo., et al. vs. J.H. Frappier, Director, Dept. of Consumer Affairs, et al.
The Missouri Psychological Assn., a Missouri not-for-profit Corp., et al., No. 65881

Gentlemen:

This is to advise that the Court this day entered the following order in the above entitled cause:

"Plffs.-Resps.-Cross-Apps.' motion for rehearing overruled."

Very truly yours,

/s/ Thomas F. Simon
Clerk.

cc:

Mr. Harvey Tettlebaum
and
Mr. Duane Benton

Mr. Tom J. Downey

Mr. Daniel P. Card, II

APPENDIX D

IN THE SUPREME COURT OF MISSOURI
En Banc

No. 65881

Blue Cross Hospital Service, Inc., of Missouri; Missouri Medical Service; Blue Cross and Blue Shield of Kansas City,

Appellants,

v.

J. H. Frappier, Director of the Department of Consumer Affairs, Regulations, Licensing in the State of Missouri; C. Donald Ainsworth, Director of the Division of Insurance, State of Missouri; The Missouri Psychological Association; Missouri Pharmaceutical Association, Inc., and M. Earl Cash,

Appellees.

(Filed April 1, 1985)

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that Blue Cross Hospital Service, Inc. of Missouri, Missouri Medical Service, and Blue Cross and Blue Shield of Kansas City, the appellants named above, hereby appeal to the Supreme Court of the United States from the final judgment of the Supreme Court of Missouri entered in this action on December 18, 1984, and as to which appellants' motion for rehearing was denied by order entered January 15, 1985. The judgment appealed from reversed the judgment of the circuit court and remanded the case with directions for the circuit court to enter a judgment declaring that House Bill 127 is not invalid for the reasons assigned by appellants, including the contention that it is pre-empted by ERISA, 29 U.S.C. §1144.

This appeal is taken pursuant to 28 U.S.C. §1257(2).

/s/ Max O. Bagby #13225

Charles G. Siebert #19964

Robert F. Schlafly #12300
314 North Broadway
St. Louis, Missouri 63102
(314) 421-0845

Attorneys for Appellants

Certificate of Service

The undersigned, Robert F. Schlafly, hereby certifies that a copy of the foregoing Notice of Appeal to the Supreme Court of the United States was served upon all the appellees, the parties required to be served herein, by depositing the same in a United States mailbox with first-class postage prepaid on the 29th day of March, 1985, addressed to each counsel of record at his post office address as follows:

Mr. Richard L. Weiler
Assistant Attorney General
Post Office Box 899
Jefferson City, Missouri 65102
Attorney for Appellees
FRAPPIER and AINSWORTH

Mr. Thomas J. Downey
101-B West McCarty
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Attorney for Appellee
M. EARL CASH

Mr. Harvey M. Tettelbaum
215 East High Street
Post Office Box 1251
Jefferson City, Missouri 65102
Attorney for Appellee
MISSOURI PHARMACEUTICAL ASSOCIATION

Mr. Daniel P. Card, II
Love, Lacks, McMahon & Paule
7701 Forsyth Blvd. - Suite 670
St. Louis, Missouri 63105-1893
Attorney for Appellee
THE MISSOURI PSYCHOLOGICAL ASSOCIATION

/s/ Robert F. Schlafly

APPENDIX E

Section 354.010(3)(4) of House Bill 127 as passed.

354.010. As used in sections 354.010 to 354.380, unless the context clearly indicates otherwise, the following terms mean: . . .

(3) "Health services", the health care and services provided by hospitals, or other health care institutions, organizations, associations or groups, and by doctors of medicine, osteopathy, dentistry, chiropractic, optometry and podiatry, nursing services, medical appliances, equipment and supplies, drugs, medicines, ambulance services, and other therapeutic services and supplies;

(4) "Health services corporation", any not for profit corporation heretofore or hereafter organized or operating for the purposes of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care and other health care and services, or reimbursement therefor, may be furnished to a member or beneficiary;

APPENDIX F

Section 354.027 of House Bill 127 as passed.

354.027. A health services corporation which provides its members or beneficiaries with coverage for certain services or reimbursement therefor, shall provide such coverage or reimbursement in all situations in which the covered service is performed by a person duly licensed to perform such service. No health service corporation may discriminate in its coverage or reimbursement amounts for covered services among persons duly licensed to provide such covered services. The provisions of this section shall not apply to any federally qualified health maintenance organization. This section shall apply to all contracts issued or renewed on or after January 1, 1984.

APPENDIX G

Section 354.090.2 of House Bill 127 as passed

2. In lieu of direct payment from an insured for goods or services furnished, a pharmacist may take an assignment of such insured's right to reimbursement for those goods or services provided to a member of a health services corporation. No health service corporation may refuse to pay the pharmacist any payment due the insured under the terms of the policy or contract.

APPENDIX H

Section 375.936(11)(b) of House Bill 127 as passed.

"375.936. The following are hereby defined as "unfair methods of competition" and "unfair and deceptive acts or practices" in the business of insurance:" . . .

(11) "Unfair discrimination" . . . .

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, including any unfair discrimination by not permitting the insured full freedom of choice in the selection of any duly licensed physician, surgeon, optometrist, chiropractor, dentist, psychologist, pharmacist, pharmacy, or podiatrist; provided that the addition of psychologist shall be effective January 1, 1984, and applied to contracts issued by health service corporations and insurance companies doing business in this state after such effective date, and to existing group contracts on the later of the next renewal date or the expiration of any applicable collective bargaining contract, if the services are covered by the terms of the contract when rendered by a licensed physician or doctor of medicine;"

APPENDIX I

ERISA preemption clause - 29 U.S.C. §1144(a)

"(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

ERISA insurance exception to preemption - 29 U.S.C. §1144(b)(2)(A)

"except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

ERISA definition of "employee welfare benefit plan" - 29 U.S.C. §1002(1)

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

ERISA definition of "employee benefit plan" - 29 U.S.C. §1002(3)

"The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan."

APPENDIX K

Section 2(b) of the McCarran - Ferguson Act - 15 U.S.C. §1012(b)

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

APPENDIX L

STATE LAWS REQUIRING PAYMENT FOR SERVICES RENDERED BY VARIOUS TYPES OF HEALTH CARE PROVIDERS

Statutory Citation	Type of Provider[1]	Number of Provider Types	Number of Mandated Provider Sections
Alabama (Ala. Code)			
§27-1-10	Chiropractor		
§27-1-11	Dentist		
§27-1-15	Podiatrist		
§27-1-18	Psychologist		
§27-1-18	Psychiatrist		
§27-19-39	Optometrist		
		6	5
Alaska (Alaska Stat.)			
§21.42.355	Nurse-Midwife		
§21.89.040	Optometrist		
		2	2
Arizona (Ariz. Rev. Stat. Ann.)			
§20-1406	Licensed Providers		
§20-1406	Optometrist		
§20-1406	Podiatrist		
§20-1406	Dentist		
§20-1406.01	Psychologist		
§20-1406.01	Chiropractor		
		5*	2
Arkansas (Ark. Stat. Ann.)			
§66-3212.2	Optometrist		
§66-3212.4	Podiatrist		
§66-3212.6	Psychologist		
§66-3212.8	Dentist		
		4	4

[1] Other than physician and surgeon

* The number does not include types of providers under a general statutory designation such as "a person duly licensed."

California (Cal. Ins. Code (West))			
§10176	Psychologist		
§10176	Social Worker		
§10176	Counselor		
§10176	Speech Pathologist		
§10176	Audiologist		
§10176	Registered Nurse		
§10176	Chiropractor		
§10176	Dentist		
§10176	Podiatrist		
§10176	Optician		
§10176	Optometrist		
§10176	Occupational Therapist		
§10176.2	Physical Therapist		
		13	2
Colorado (Col. Rev. Stat.)			
§10-8-103	Osteopath		
§10-8-103	Dentist		
§10-8-103	Optometrist		
§10-8-103	Psychologist		
§10-8-103	Chiropractor		
§10-8-103	Podiatrist		
		6	1
Connecticut (Conn. Gen. Stat. Ann. (West))			
§38-174d	Psychologist		
§38-174d	Psychiatrist		
§38-174d	Social Workers for Child Guidance Clinic		
§38-174h	Dentist		
§38-174q	Occupational Therapist		
§38-174v	Nurse midwife		
§38-174v	Nurse practitioner		
§38-174v	Psychiatric mental health clinical nurse specialist		
		8	4
Delaware (Del. Code Ann.)			
24 § 511	Podiatrist		
24 § 717	Chiropractor		
24 § 2101	Optometrist		
		3	3

Florida (Fla. Stat. Ann. (West))			
§627.419	Dentist		
§627.419	Optometrist		
§627.419	Podiatrist		
§627.6406	Nurse-Midwife		
		4	2
Georgia (Ga. Code)			
§33-24-27	Psychologist		
§33-24-27	Chiropractor		
§33-24-27.1	Optometrist		
		3	2
Hawaii (Hawaii Rev. Stat.)			
§431-450	Optometrist		
§431-499	Dentist		
§431-500	Psychologist		
		3	3
Idaho (Idaho Code)			
§41-2103	Podiatrist		
§41-2103	Optometrist		
		2	1
Illinois (Ill. Ann. Stat. Ins. Code (Smith-Hurd))			
§364	Dentist		
§370b	Osteopath		
§370b	Chiropractor		
§370c	Psychologist		
		4	3
Indiana (Ind. Code Ann. (Burns))			
§27-8-6-1	Dentist		
§27-8-6-1	Podiatrist		
§27-8-6-1	Osteopath		
§27-8-6-1	Optometrist		
§27-8-6-1	Chiropractor		
		5	1
Iowa (Iowa Legis. Serv. (West))			
§509.3 & 514.7	Optometrist		
		1	2
Kansas (Kan. Stat. Ann.)			
§40-2, 100	Optometrist		
§40-2, 100	Dentist		
§40-2, 100	Podiatrist		
§40-2, 104	Psychologist		
		4	2

Kentucky (Ky. Rev. Stat.)			
§304.18-095	Optometrist		
§304.18-095	Osteopath		
§304.18-097	Dentist		
		3	2
Louisiana (La. Rev. Stat. Ann. (West))			
§22:213.1	Dentist		
§22:662	Podiatrist		
§22:664	Optometrist		
§22:665	Psychologist		
§22:668	Chiropractor		
§22:669	Social Worker		
		6	6
Maine (Me. Rev. Stat. Ann.)			
24-A § 2744	Psychologist		
24-A § 2744	Social Worker		
24-A § 2744	Psychiatric Nurse		
		3	1
Maryland (Md. Ann. Code Art. 48A)			
§477-O	Social Worker		
§477T	Nurse-Practitioner		
§489	Chiropractor		
§490A	Psychologist		
§490	Podiatrist		
§490A-1	Dentist		
§490A-2	Nurse-Midwife		
		7	7
Massachusetts (Mass. Gen. Laws. Ann. Ch. 175 (West))			
§108B	Dentist		
§108D	Chiropractor		
§110	Optometrist		
§110	Podiatrist		
		4	3
Michigan (Mich. Comp. Laws Ann.)			
§500.2243	Optometrist		
§500.2239	Dentist		
§500.3475	Psychologist		
§500.3475	Chiropractor		
§500.3475	Podiatrist		
		5	3

Minnesota (Minn. Stat. Ann. (West))			
§62A.15	Optometrist		
§62A.15	Chiropractor		
§62A.15	Registered Nurse		
§62A.043	Dentist		
§62A.043	Podiatrist		
§62A.152	Psychologist		
		6	3
Mississippi (Miss. Code Ann.)			
§83-41-203	Optometrist		
§83-41-209	Dentist		
§83-41-211	Psychologist		
§83-41-213	Nurse Practitioner		
§83-41-215	Chiropractor		
		5	5
Missouri (Mo. Ann. Stat. (Vernon))			
§375.936(11)(b)	Optometrist		
§375.936(11)(b)	Chiropractor		
§375.936(11)(b)	Dentist		
§375.936(11)(b)	Psychologist		
§375.936(11)(b)	Pharmacist		
§375.936(11)(b)	Podiatrist		
§354.027	"Person duly licensed" to perform covered services		
§354.090-2	Pharmacist (assignment)		
		6*	3
Montana (Mont. Code Ann.)			
§33-22-111	Dentist		
§33-22-111	Osteopath		
§33-22-111	Chiropractor		
§33-22-111	Optometrist		
§33-22-111	Chiropodist		
§33-22-111	Psychologist		
§33-22-111	Nurse Specialist		
§33-22-111	Pharmacist		
		8	1
Nebraska (Neb. Rev. Stat.)			
§44-513	Osteopath		
§44-513	Chiropractor		
§44-513	Optometrist		
§44-513	Psychologist		
§44-513	Dentist		
§44-513	Podiatrist		
		6	1

Nevada (Nev. Rev. Stat.)			
§689A.380	Dentist		
§689A.380	Osteopath		
§689A.380	Chiropractor		
§689A.380	Oriental Medicine		
§689A.380	Podiatrist		
§689A.380	Optometrist		
§689B.038	Psychologist		
§689B.039	Chiropractor		
		8	3
New Hampshire (N.H. Rev. Stat. Ann.)			
§415-18a	Licensed Pastoral Counselor		
§415-18a	Psychologist		
§415-18a	Psychiatrist		
§415-18a	Certified Clinical Social Worker		
		4	1
New Jersey (N.J. Stat. Ann. (West))			
§17B:27-50	Psychologist		
§17B:27-51	Optometrist		
§17B:27-51.1	Chiropractor		
§17B:27-51.8	Dentist		
		4	4
New Mexico (N.M. Stat. Ann.)			
§59-18-19	Optometrist		
§59-18-19	Psychologist		
§59-18-19	Podiatrist		
§59-18-19	Nurse Midwife		
		4	1
New York (N.Y. Ins. Law (McKinney))			
§162a	Nurse Midwife		
§221	Podiatrist		
§221	Optometrist		
§221	Dentist		
§221	Psychologist		
§221	Chiropractor		
		6	2
North Carolina (N.C. Gen. Stat.)			
§58-260	Optometrist		
§58-260	Podiatrist		
§58-260	Dentist		
§58-260	Chiropractor		
§58-260	Psychologist		
		5	1

Ohio (Ohio Rev. Code Ann. (Baldwin))			
§3923.23	Osteopath		
§3923.23	Optometrist		
§3923.23	Chiropractor		
§3923.23	Podiatrist		
§3923.231	Psychologist		
§3923.232	Dentist		
§3923.233	Nurse Midwife		
		7	4
Oklahoma (Okla. Stat. Titl. 36)			
§3634	Podiatrist		
§3634	Psychologist		
§3634	Social Worker		
§6051	Optometrist		
§6055	Any practitioner licensed under the healing arts		
		4*	3
Oregon (Or. Rev. Stat.)			
§743.117	Optometrist		
§743.123	Psychologist		
§743.128	Nurse Practitioner		
§743.132	Dentist		
§743.132	Denturist		
§743.135	Social Worker		
		6	5
Pennsylvania (Pa. Stat. Ann. Tit. 40 (Purdon))			
§1511	Osteopath		
§1511	Dentist		
§1511	Chiropractor		
§1511	Podiatrist		
§1511	Physical Therapist		
§3102	Nurse Midwife		
		6	2
Rhode Island (R.I. Gen. Laws)			
§27-18-25	Chiropractor		
§27-18-25	Osteopath		
		2	1
South Carolina (S.C. Code Ann.)			
§38-35-90	Podiatrist		
§38-35-90	Oral Surgeon		
		2	1

South Dakota (S.D. Codified Laws Ann.)			
§58-17-53	Optometrist		
§58-17-54	Dentist		
§58-17-54	Osteopath		
§58-17-54	Chiropractor		
§58-17-54	Podiatrist		
		5	2
Tennessee (Tenn. Code Ann.)			
§56-7-108	Optometrist		
§56-7-108	Psychologist		
§56-7-108	Podiatrist		
§56-7-116	Chiropractor		
§56-7-1002	Dentist		
		5	3
Texas (Tex. Ins. Code Ann. (Vernon))			
§21.35A	Psychologist		
§21.52	Podiatrist		
§21.52	Dentist		
§21.52	Chiropractor		
§21.52	Optometrist		
§21.52	Audiologist		
§21.52	Speech-Language Pathologist		
		7	2
Utah (Utah Code Ann.)			
§31-20-3	Optometrist		
§31-27-24	Dentist		
§31-27-24	Chiropodist		
§31-27-24	Duly licensed practitioner of healing arts		
		3*	2
Virginia (Va. Code)			
§38.1-347.1	Chiropractor		
§38.1-347.1	Optometrist		
§38.1-347.1	Optician		
§38.1-347.1	Psychologist		
§38.1-347.1	Social Worker		
§38.1-347.1	Podiatrist		
§38.1-347.1	Chiropodist		
§38.1-348.5	Dentist		
		8	2

Washington (Wash. Rev. Code Ann.)			
§48.20.390	Podiatrist		
§48.20.410	Optometrist		
§48.20.411	Registered Nurse		
§48.20.412	Chiropractor		
§48.20.414	Psychologist		
§48.20.416	Dentist		
		6	6
West Virginia (W. Va. Code)			
§33-6-30	Dentist		
§33-6-30	Podiatrist		
§33-6-30	Chiropractor		
§33-6-30	Optometrist		
§33-16-3e	Registered Nurse		
§33-16-3e	Nurse Midwife		
		6	2
Wisconsin (Wis. Stat. Ann. (West))			
§628.33	Chiropractor		
§632.87	Optometrist		
		2	3
Wyoming (Wyo. Stat.)			
§26-22-101	"Person licensed under laws of state to treat illness or disability or perform the health services"		
		0*	1

TOTALS

States: 48 Statutes: 125